STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155196		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00			(X3) DATE SURVEY COMPLETED	
		155196	B. WING		06/10	/2014
	PROVIDER OR SUPPLIE	R /ING COMMUNITY	3525	ET ADDRESS, CITY, STATE, ZIP CODE 5 E HANNA AVE ANAPOLIS, IN 46237		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
F000000						
F000000	State Licensure included a State Survey.  This visit was in Investigation of Survey dates: J. 10, 2014  Facility number Provider number AIM number: 1  Survey team: Dorothy Plumm Marsha Smith, I. Karyn Homan, I.	er: 155196 00290000 her, RN-TC RN RN 7 (June 1, 2, 3, 4, 6, 9, and	F000000			
	Census payor ty Medicare: 20 Medicaid: 33 Other: 83 Total: 136	pe:				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

TITLE

000103

(X6) DATE

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/02/2014 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155196		A. BUILDING  B. WING	00 	COMPLETED 06/10/2014
	ROVIDER OR SUPPLIER EIM HEALTH & LIVING COMMUNITY	3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE IAPOLIS, IN 46237	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	These deficiencies reflect state findings cited ir accordance with 410 IAC 16.2-3.1.  Quality Review completed on June 17, 2014; b Kimberly Perigo, RN.			
F000280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.			
	A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons			
	Based on observation, record review, and interview, the facility failed to ensure a care plan was accurate and updated for a resident who was injured during a surface	F000280	Date: 6/20/2014 Tag # F 280 SS=D Right to participate planning care Description of findings: The facility failed to ensure a care plan was accura and updated for a resident who was injured during a surface to	ate o

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QK5L11

Facility ID: 000103

If continuation sheet Page 2 of 26

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJII	DDIC	00	COMPL	ETED
		155196	A. BUIL B. WING			06/10/	2014
			B. WINC	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹			HANNA AVE		
AI TENIL	EIM HEALTH & LIV	ING COMMUNITY			IAPOLIS, IN 46237		
ALIENT	EIN HEALTH & LIV	ING COMMONT F		INDIAN	IAPOLIS, IN 40237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	to surface transfe	er. (Resident #A)			surface transfer. What		
					Corrective action(s) will be		
	Findings include	<b>:</b>			accomplished for those reside		
		•			found to have been affected b	У	
	The clinical man-	ord of Resident #A was			the deficient practice? 1. Resident #A care plan and sta	aff's	
					assignment sheets checked to		
		/14 at 10:00 a.m.			assure the proper level of	-	
	Diagnoses included, but were not limited				assistance needed for transfe	rs is	
	to, muscle weakness, difficulty walking,				accurate. How other resident		
	and dementia.				having the potential to be affe	cted	
					by the same deficient practice		
	A quarterly Min	imum Data Set			be identified and what correct	ive	
	1 *				action(s) will be taken? 1.		
	assessment, dated 1/30/14, and an annual				Residents who require the		
	Minimum Data Set dated 5/7/14, both				assistance of healthcare work for transfers have the potentia		
	indicated Reside	ent #A was severely			be affected. The care plans a		
	cognitively impa	aired and needed			nurse aide assignment sheets		
	extensive assista	ince of 2 people for			have been audited for those		
	transferring.				residents who need assistanc	е	
					with transfers and the care pla	ans	
	Δ care plan for I	Resident #A, dated			and nurse aide assignment		
	-				sheets reflect the correct		
	•	rent through 8/21/14,			assistance staff needs to prov	ide	
		s at risk for falls related			to ensure safe transfers are		
	to impaired mob	ility and dementia. The			happening. What measures be put into place or what systems		
	goal was she wo	uld remain free from			changes will be made to ensu		
	injury. Approac	hes were, bed in low			that the deficient practice does		
	position (initiate	d 1/23/14), encourage			not recur? 1. Employees will		
		ne a standing position			in-serviced and checked off or		
		4/28/12), give resident			safe and effective transfer		
		s not to ambulate/transfer			techniques. 2. Unit managers		
					designee will audit 4 transfers		
		ce (initiated 4/28/12),			randomly on all shifts 7 days	-	
		nd personal items within			week, weekly for 60 days and upon completion will audit 4	ı	
	reach (initiated 4	4/28/12), and provide			transfers, randomly on all shift	ts 7	
	toileting assistan	ice per resident's needs			per week, every thirty days.		
	(initiated 4/28/12	2).			All new hires will receive trans		
					training with return demonstra		
	I		1		I		

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/02/2014 FORM APPROVED OMB NO. 0938-0391

IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196	A. BUILDING	DIE CONSTRUCTION  00	(X3) DATE COMP. — 06/10	
PROVIDER OR SUPPLIER		352	REET ADDRESS, CITY, STATE, ZIP 25 E HANNA AVE DIANAPOLIS, IN 46237	CODE	
SUMMARY S' (EACH DEFICIEN REGULATORY OR  A care plan for F 5/9/12, and curre indicated she required with most activitate to weakness, imprognitive deficits side rails (on both assist with bed intransfers, transfer person) using gate approaches were approaches were An Incident Repusent by the faciliate Department of H 5/6/14 at 6:30 p.:  Assistant (CNA) Resident #A from bed. During the received a 14 cereived a 14 cereived.	ING COMMUNITY  FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  Resident #A, dated ent through 8/21/14, quired extensive assist lies of daily living related paired mobility, and s. Approaches included, th sides of the bed) up to hobility/positioning, r with assist of 1 (staff lit belt for safety. All linitiated 5/9/12.  Port Form, dated 5/7/14, ty to the Indiana State lealth, indicated on lim., a Certified Nursing was transferring m her wheelchair to her transfer, the resident ntimeter (cm) laceration	352	25 E HANNA AVE DIANAPOLIS, IN 46237  PROVIDERS PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	or of nursing 3 different a all a, weekly for bractice will uality vill be put dits will be binimum of num uracy will be bifer used or actions will the goal is trator/or at date the loor of nursing and additional actions at date the loor of nursing a different a different actions will and a different	(X5) COMPLETION DATE
lower leg. The land covered, and an emergency ro treatment. The resident received fastening tissue/s area of the lacera leg. The report in transfer program assignment sheet	vation on 6/2/14 at 1:00				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QK5L11

Facility ID: 000103

If continuation sheet

Page 4 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE :		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155196	B. WIN			06/10/	2014
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
AL TENILI	EIM HEALTH & LIV	INC COMMUNITY			HANNA AVE		
					APOLIS, IN 46237		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION DATE
IAG		Ouring an interview with		IAG	,		DATE
		and the Director of					
		14 at 11:30 a.m., Unit					
	Manager #1 indicated it was Resident #A's right leg, not her left leg, which received the skin laceration.						
	10001 VOU HIC SKII	i iacciation.					
	A nurse's note, dated 5/6/14 at 6:30 p.m.,						
	indicated, "called to the room per						
		_					
	CNA. CNA reported resident had a skin tear and was bleeding. Upon entering the						
	resident's room, signee observed resident						
	in bed and her right LE [lower extremity]						
		m a [large] laceration.					
	1	rea, reported to MD					
		on unit [MD observed],					
	-	cm in length, 3 cm open					
	with 6 cm skin f	-					
	visibleResiden	• •					
		From laceration. Resident					
	_	is asking questions of					
	_	and what was wrong.					
	Staff reassured r	_					
	Starr reassured r	obiaciit.					
	A nurse's note d	ated 5/6/14 at 6:36 p.m.,					
		oulance was called as the					
		d the resident to be					
		emergency room. A					
		d 5/6/14 at 7:00 p.m.,					
		ident was transported to					
	the hospital.	india mad dansported to					
	ino mospitui.						
	A nurse's note d	ated 5/6/14 at 10:33 p.m.					
		nt #A returned from the					
	indicated Reside	nt mr returned from the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QK5L11

Facility ID: 000103

If continuation sheet Page 5 of 26

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	
		155196	B. WIN	IG		06/10/2	2014
NAME OF P	PROVIDER OR SUPPLIEF	3	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					HANNA AVE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY		INDIAN.	APOLIS, IN 46237		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	hospital at 10:10	-					
	1	has 24 staples in place to					
	RLE [right lower extremity], that need to be removed in 14 days"						
	Paviou of an A	ssociate Warning Notice,					
		•					
	provided by the Director of Nursing on 6/2/14 at 3:10 p.m., indicated, "Employee						
	_	ent as 1 person assist					
		it sheet states 2 person."					
	when assignmen	it sheet states 2 person.					
	During an interview with Unit Manager						
	#1 on 6/5/14 at 3:00 p.m., she indicated						
		have used 2 people to					
		t #A on 5/6/14. She					
		ident was inconsistent in					
		sist with transfers and that					
	I -	ade Resident #A, "A 2					
	person transfer."						
	person transfer.						
	Review of Resid	lent #A's current care					
		/12 and 5/9/12, the care					
		licate Resident #A was a					
	1 ^	r. Further information					
	_	er need for a 2 person					
		careplanned was					
		the DON on 6/5/14 at					
	_	orther information was					
	_	vey exit on 6/9/14 at					
	11:15 a.m.	voy exit on or 7/14 at					
	11.13 a.III.						
	This Federal tag	relates to Complaint					
	IN00148896.	Totales to Complaint					
	11100170070.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QK5L11

Facility ID: 000103

If continuation sheet Page 6 of 26

STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING	00	COMPL	ETED
		155196	B. WING			06/10/	2014
NAME OF F	ADOLUDED OD GUDDI IED		I	_	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIER			3525 E	HANNA AVE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY		INDIAN	APOLIS, IN 46237		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	I F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
	3.1-35(d)(2)(B)						
F000309 SS=D	must provide the reservices to attain of practicable physic psychosocial well-the comprehensive care.  Based on observer record review, the physician's order thinner, were cleared in a for 1 of 14 resident medication admiresulted in a medication ad	BEING st receive and the facility necessary care and or maintain the highest ral, mental, and releing, in accordance with releasessment and plan of relation, interview, and relation facility failed to ensure rest for warfarin, a blood rarly written on the relationstration record (MAR) rents reviewed for correct relationstration, which relation administration	F000	0309	Date: 6/20/2014 Tag # F 309 SS=D Provide care/services for highest wellbeing. Description findings: The facility failed to ensure physician's orders for warfarin, a blood thinner, were clearly written on the MAR for 14 residents reviewed for corred administration, which resulted in a medication error. What Corrective action(s) will accomplished for those reside found to have been affected be the deficient practice? 1. Coumadin orders for resident #156 were immediately correctly physician and family notified, resident #156 is receiving the proper dose of Coumadin. 2 Resident #156 was assessed no abnormal finding from the deficient practice, lab work was performed to ensure the residents' therapeutic levels a	or n of e 1 of ect be nts y tted,	07/10/2014
	,	, congestive heart failure,			appropriate. Lab report shown		
		rial fibrillation, and iron			normal levels. How other		
	deficiency anem	ia.			residents having the potential		
					be affected by the same defici practice will be identified and	ent	
	During an observ	vation of medication			what corrective action(s) will b	e	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QK5L11

Facility ID: 000103

If continuation sheet Page 7 of 26

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SU	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIT	LDING	00	COMPLE	TED
		155196		LDING		06/10/2	2014
			B. WIN		ADDRESS SITY STATE TIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
					HANNA AVE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY		INDIAN	IAPOLIS, IN 46237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	administration o	n Wednesday, 6/4/14 at			taken? 1. All resident s who		
	4:07 p.m., Licen	sed Practical Nurse			receive medications have the		
	_	bserved administering			potential to be affected by this		
	· ′	•			deficient practice. 2. All		
	warfarin 5 mg (milligrams) to Resident				Physicians orders will be read		
	#156.				and checked in Morning clinic		
					meeting by the Unit managers designee. 3. Medication orde		
	During a review	of the recapitulation of			will also be verified monthly to		
	physician's orders for Resident #156 on				ensure no duplicate orders ex		
	6/5/14 at 9:30 a	.m., the warfarin order			Medication pass audits/che		
					off will be completed on all		
	indicated, "Take 2.5 mg PO (by mouth)				Licensed staff and continued		
	Monday Wednesday and Friday. Take 5				monitoring with 4 audits rando	mly	
	-	Thursday Saturday and			on all shifts 7 days per week f	or	
	Sunday." A rev	iew of the MAR			90 days. 5. Medications aud		
	(Medication Adı	ministration Record) for			will then be completed on all s		
	Resident #156, i	ndicated Resident #156			quarterly continuously. 6. The		
		ministered on 6/2, 6/3,			director of nursing or designed	9	
		nday, Tuesday, and			will be responsible to ensure		
		-			compliance. What measures		
		he documentation of the			be put into place or what syste changes will be made to ensu		
		f warfarin included staff			that the deficient practice does		
	initials. The dos	sage of the warfarin			not recur? 7. All Physicians		
	administered wa	s not included/indicated			orders will be read and checke	ed	
	in the document	ation.			in Morning clinical meeting by		
					Unit managers/or designee. 8		
	During on inter-	view with the Director of			Medication orders will also be		
	_				verified monthly to ensure no		
		on 6/5/14 at 11:15 a.m.,			duplicate orders exist. 9.		
	the DON indicat	ted the order for warfarin			Medication pass audits/check		
	should have bee	n entered onto the MAR			will be completed on all Licens		
	as two separate	administrations, one for			staff and continued monitoring	·	
		ne DON indicated			with random 4 audits per weel including all shifts 7 days per	۸,	
		hould have received 2.5			week for 90 days. 10.		
					Medications audits will then be	و	
	_	on 6/4/14, when warfarin			completed on all staff quarterly	I	
	5 mg was admin	istered.			continuously. 11. The directo		
					nursing or designee will be		
	On 6/5/14 at 9:3	0 a.m., the DON			responsible to ensure		

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155196	B. WIN			06/10/	2014
	PROVIDER OR SUPPLIER			3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE APOLIS, IN 46237		
(X4) ID	SUMMARY S'	FATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	"Medication Adı Policies & Proce policy was the or facility. The pol "Medications a prescribed in acc	ated policy titled, ministration: General dures," and indicated the ne currently used by the icy indicated are administered as cordance with good ls and practices"			compliance. How the correct action(s) will be monitored to ensure the deficient practice w not recur, i.e., what quality assurance program will be put into place? 1. All audits will b brought to QA for a minimum of 120 days. 2. The administration designee will ensure compliance. What date the systemic changes will be completed? 7/10/2014	rill e of	
F000323 SS=G	The facility must e environment rema hazards as is poss receives adequate assistance device.  Based on observinterview, the factorist was safe surface to another resident receivintear to her leg, a room, and 24 stafor 1 of 3 resider accidents. (Residenting include	RVISION/DEVICES nsure that the resident ins as free of accident sible; and each resident e supervision and s to prevent accidents.  ation, record review, and cility failed to ensure a ely transferred from one er, which resulted in the g a 14 centimeter skin trip to the emergency ples to close the wound, nts reviewed for dent #A)  : rd of Resident #A was	F00	0323	Date: 6/20/2014 Tag # F 323 SS=G Free of accident hazards/supervision/devices Description of findings: The facility failed to ensure a reside was safely transferred from on surface to another, which resu in the resident receiving a 14 c skin tear to her leg, a trip to the ER, and 24 staples to close the wound, for 1 of 3 residents reviewed. What Corrective action(s) will be accomplished those residents found to have been affected by the deficient practice? 1. Resident #A carplan and staff's assignment sheets checked to assure the proper level of assistance need	ent e Ited cm e e for	07/10/2014

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QK5L11

Facility ID: 000103

If continuation sheet

Page 9 of 26

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DUILDING	00	COMPLETED
		155196	A. BUILDING B. WING		06/10/2014
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIEI	₹		E HANNA AVE	
ALTENH	EIM HEALTH & LIV	ING COMMUNITY		NAPOLIS, IN 46237	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG		DATE
		ded, but were not limited		for transfers is accurate. How	N
	to, muscle weak	ness, difficulty walking,		other residents having the potential to be affected by the	
	and dementia.			same deficient practice will be	
				identified and what corrective	
	A quarterly Min	imum Data Set		action(s) will be taken? 1.	
	assessment, dated 1/30/14, and an annual Minimum Data Set dated 5/7/14, both indicated Resident #A was severely			Residents who require the	
				assistance of healthcare work	
				for transfers have the potential be affected. The care plans a	
	cognitively impa	•		nurse aide assignment sheets	
				have been audited for those	
		ance of 2 people for		residents who need assistance	e
	transferring.			with transfers and the care pla	ans
				and nurse aide assignment	
	An Incident Rep	oort Form, dated 5/7/14,		sheets reflect the correct	.,
	sent by the facil	ity to the Indiana State		assistance staff needs to prov to ensure safe transfers are	/ide
	Department of H	Health, indicated on		happening. What measures	s will
	5/6/14 at 6:30 p.	m., a Certified Nursing		be put into place or what syst	
	Assistant (CNA)	) was transferring		changes will be made to ensu	
		m her wheelchair to her		that the deficient practice doe	
	bed During the	transfer, the resident		not recur? 1. Employees will	
	_	ntimeter (cm) laceration		in-serviced and checked off o safe and effective transfer	n
		f the skin) to her left		techniques. 2. Unit manager	s/or
		laceration was cleaned		designee will audit 4 random	
	_	d Resident #A was sent to		transfers on all shifts 7 days	per
	l '	oom for evaluation and		week for 60 days and upon	
	1			completion will audit 4 randor	
		report indicated the		transfers, all shifts 7 days per week every thirty days. 3. A	
		d 24 staples (a means of		new hires will receive transfer	
	_	skin to one another) to		training with return demonstra	
		aceration on her left lower		check offs. 4. Director of nur	-
		indicated the resident's		or designee will audit 3 rando	
		n, plan of care, and		transfers, including all shifts 7 days per week for 60 days.	
	assignment shee	t were being reviewed,		How the corrective action(s) v	vill
	the bed was pad	ded, cognitively intact		be monitored to ensure the	···· [
	residents on the	unit were being		deficient practice will not recu	r, [
	interviewed rega	arding their transfers, and		i.e., what quality assurance	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QK5L11

Facility ID: 000103

If continuation sheet

Page 10 of 26

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		155196	B. WIN			06/10/2014
NAME OF B					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	C		3525 E	HANNA AVE	
	EIM HEALTH & LIV	ING COMMUNITY			APOLIS, IN 46237	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL  LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA'  DEFICIENCY)	TE COMPLETION DATE
IAU		<u> </u>		TAU	program will be put into place?	
		spended pending			All audits will be brought to	
	investigation.				for a minimum of 120 days. 2	. A
	Daning and abase				minimum threshold of 95%	
	During an observation on 6/2/14 at 1:00 p.m., Resident A's right leg had a dressing on it. During an interview with Unit Manager #1, and the Director of Nursing, on 6/6/14 at 11:30 a.m., Unit Manager #1 indicated it was Resident				accuracy will be expected on t transfer technique audit tools	ne
					used or additional corrective	
					actions will be put into place u	ntil
					the goal is met. 3. The	
					administrator or designee will ensure compliance. By What	
	_				date the systemic changes wil	
	"	ot her left leg, which			completed? 7/10/2014	
	received the skir	1 laceration.				
	indicated, "cal CNA. CNA rep tear and was ble resident's room, in bed and her ri was bleeding from assessed the a [medical doctor] Laceration is 16 with 6 cm skin for visibleResident havebleeding from the control of the co	ort continues to from laceration. Resident is asking questions of and what was wrong.				
	indicated an aml physician wante evaluated in the	ated 5/6/14 at 6:36 p.m., bulance was called as the d the resident to be emergency room. A ed 5/6/14 at 7:00 p.m.,				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QK5L11

Facility ID: 000103

If continuation sheet

Page 11 of 26

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155196	A. BUII	LDING	00	COMPL 06/10/	
		133190	B. WIN			00/10/	2014
NAME OF I	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP CODE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY			HANNA AVE APOLIS, IN 46237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	16	DATE
	indicated the res	ident was transported to					
	the hospital.						
		ated 5/6/14 at 10:33 p.m.					
	indicated Resident #A returned from the						
	hospital at 10:10	•					
	indicated, "She has 24 staples in place to						
	RLE, [right lower extremity] that need to						
	be removed in 14 days"						
	Davison of an Associate Warning Nation						
	Review of an Associate Warning Notice, provided by the Director of Nursing on						
	1 1	•					
	_	m., indicated, "Employee					
		ent as 1 person assist					
	when assignmen	at sheet states 2 person."					
	During an interv	riew with CNA #2 on					
		m., she indicated					
		been assigned to her on					
		t, 5/6/14. CNA #2					
		asn't really sure how					
		her skin tear. She					
	_	signment sheet on 5/6/14,					
		d Resident #A was a 2					
		but she did not enlist the					
	_	staff person to transfer					
	the resident.	starr person to transfer					
	are resident.						
	During an interv	riew with the Director of					
	_	14 at 3:00 p.m., she					
		asn't really sure what					
		ation on Resident #A's					
		should have used 2					
	people to transfe						
	1 1						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QK5L11 Facility ID: 000103

If continuation sheet Page 12 of 26

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:  155196	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 06/10/2014	
	PROVIDER OR SUPPLIER EIM HEALTH & LIVING COMMUNITY	3525 E	STREET ADDRESS, CITY, STATE, ZIP CODE  3525 E HANNA AVE INDIANAPOLIS, IN 46237		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
F000371 SS=E	During an interview with Unit Manager #1 on 6/5/14 at 3:00 p.m., she indicated CNA #2 should have used 2 people to transfer Resident #A on 5/6/14. She indicated the resident was inconsistent in her ability to assist with transfers and that was why they made Resident #A, "A 2 person transfer."  This Federal tag relates to Complaint IN00148896.  3.1-45(a)(2)  483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview the facility failed to assure 66 of 67 residents, who ate food prepared in the kitchen, received food prepared, distributed, and served under sanitary conditions.  Finding include:  During the service of evening meal on 06-01-14 at 4:55 p.m., the following were observed:	F000371	6/20/2014 F371 SS=E Store/Prepare/ Serve-Sanitary Findings= Facility failed to ass 66 of 67 residents, who ate for prepared in the kitchen, receive food prepared, distributed and served under sanitary condition. What corrective actions we be accomplished for those residents found to have been affected by the deficient practice; a. The residents has been assessed and no resident were identified as being negatively affected by the	sure pod yed l ons. yill n	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QK5L11

Facility ID: 000103

If continuation sheet

Page 13 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) E			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITE	LDING	00	COMPLETED
		155196	A. BUI. B. WIN		<del></del>	06/10/2014
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIEF	₹		1	HANNA AVE	
A1 TENII 1	EIM HEALTH & LIV	UNIC COMMUNITY			APOLIS, IN 46237	
ALIENT	EIIVI NEALTH & LIV	TING COMMUNITY		INDIAN	APOLIS, IN 46237	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	1) Dietary Staff	# 1 was observed on the			deficient practice(s). 2. How	
	service line to ha	andle the bread with			other residents having the	
	gloved hands when preparing chicken				potential to be affected by th	
	salads sandwiches. After staff had				same deficient practice will b	
					identified and what corrective	e
	handled the serving trays, the plates,				actions will be taken; a. All	stical
	ketchup bottle, lettuce, tomato, cheese,				other residents have the poter to be affected by the deficient	iliai
	handle of the scoop use to get the chicken				practice(s). b. The dietary sta	off
	salad, and handled plate covers for the				and other facility staff will be in	
	room trays. Same staff was observed a				serviced on the environmental	
	few minutes later handling the buns for				sanitation and infection contro	ı
	hamburgers/cheeseburgers with same				policy to cover areas such as;	
	gloved hands.				proper gloving, when to remov	
	gioved manus.				gloves, touching environmenta	al
					surfaces and when to wash	
	Dietary Staff # 1	went out of the kitchen			hands, covering facial hair fully	
	came back in the	e kitchen touching the			with sanitary covers and other	
	door both times	and did not change			sanitary practices that are the	flon
	gloves.			policy of the Altenheim. c. Teflon skillets showing signs of wear		
					have been replaced with new	
	Dietary Staff # 1	placed gloved hand into			pans. 3. What measures will	
	_	_			be put into place or what	
		otato chips and then			systemic changes will be ma	de
	placed the chips	on the residents plates.			to ensure that the deficient	
					practice does not reoccur; a	
	Dietary staff # 1	did remove gloves after			The dietary staff and other fac	ility
	finishing the trav	ys for C-Hall and placed			staff will be in serviced on the	
		without washing hands.			environmental sanitation and	
	III III O BIO ( CS,				infection control policy to cove	
	Distant Staff !! 1	Lyvon obnomio to			areas such as; proper gloving,	
	-	was observe to wear a			when to remove gloves, touch environmental surfaces and w	~
		leaving his mustache			to wash hands, covering facial	
	uncovered while	e preparing and serving			hair fully with sanitary covers a	
	the meal.				other sanitary practices that ar	
					the policy of the Altenheim. b.	
	On 6-10-14 at 9:	:00 a m the			Teflon skillets showing signs of	
		rovided the Policy 9.1			wear have been replaced with	
	_	•			new pans. c. A CQR audit wi	
	Environmental S	Sanitation/Infection			conducted auditing the proper	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETE.		ETED		
		155196	B. WING			06/10/	2014
ALTENH (X4) ID	SUMMARY S	/ING COMMUNITY		3525 E INDIAN	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE APOLIS, IN 46237  PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	` `	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
IAU	Control, dated 2 policy was the of facility. The porestraint that eff /or facial hair (ris worn in the form of the facility of facial hair (ris worn in the form of the facility of facial hair (ris worn in the form of food equipment).  2) Dietary Staff skillet, butter, by spatula. Then proposed food equipment of facility.  On 6-10-14 at 9 Administrator proposed facility.  On 6-10-14 at 9 policy was the of facility.  On 6-10-14 at 9 policy was the of facility.  Control dated 2 policy was the of facility.  On 6-10-14 at 9 policy was the of facility.  Control dated 2 policy was the of facility.  Control dated 2 policy was the of facility.  Control dated 2 policy was the of facility of	2012, and indicated the one currently used by the licy indicated, " A hair fectively cover head and noustache and/or beard), ood preparation areas. It to prevent contamination and utensils"  ## 2 was observed to get a read, cheese, and handle a repare grilled cheese hout washing hands or s.  :00 a.m., the rovided the Policy 9.62 Sanitation/Infection 012, and indicated the one currently used by the :30 a.m., review of Policy ental Sanitation /Infection 012. Under Procedure: always washed prior to es. When donning gloves, it is made with the ll come in actual contact ach as the fingers. Gloves by of sizes so that they fit			sanitation techniques of staff, hand washing audits, equipme audits, proper gloving technique and other proper safe and effective sanitation expectation to ensure compliance is met. dietary manager or designee was randomly audit meals to include all meal times 7 days per weel ensure compliance weekly x 4 weeks, monthly x 2 months and quarterly thereafter. 4. How corrective actions will be monitored to ensure the deficient practice will not recise, what quality assurance program will be put into place. All audits will be brought to for a minimum of 120 days. but The administrator or designee ensure compliance. 5. By what date the systemic changes will be completed. July 10,2014	ues The vill le k to d the ur, e. QA	DATE
		loves are used to perform as preparing sandwiches					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ĺ	ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE SURVEY  COMPLETED	
		155196	B. WIN			06/10/2014
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE	
ALTENH	EIM HEALTH & LIV	ING COMMUNITY			HANNA AVE APOLIS, IN 46237	
(X4) ID		TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	COMPLETION DATE
TAG	thy are then disc			TAG		DATE
	cross-contamina	_				
	5. gloves are discarded when they are					
		any way. contamination				
		touching unclean				
		a refrigerator handle,				
	trash can, contact with bodily fluids (such					
	as from sneezing or coughing) or if they					
	become torn"					
	3) ON 06-06-14 at 1:10 a.m., During					
		rith the Dietary Manager				
	` ′	(5) Teflon skillets had				
	damaged or miss	_				
	# 2 prepared the	4:55 p.m., Dietary Staff				
		skillet where the Teflon				
		eeling Teflon, or the				
	Teflon was gone	<del>-</del>				
	Terroit was gone	•				
	During an interv	iew with the Dietary				
	~	0-14 at 10: 30 a.m., she				
	indicated the star	ff receive training and				
	policies are gone	e over during orientation,				
		miniseries and protocol				
		he duration of their				
	employment.					
	3.1-21(i)(3)					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

QK5L11

Facility ID: 000103

If continuation sheet

Page 16 of 26

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155196		A. BUILDING  B. WING			COMPLETED - 06/10/2014		
	ROVIDER OR SUPPLIER			3525 E	DDRESS, CITY, STATE, ZIP CODE HANNA AVE APOLIS, IN 46237		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
R000000		r a State Residential	R00	00000			
	Recertification as Survey.	y. This visit included a nd State Licensure					
		conjunction to the Complaint IN00148896.					
	Survey dates: Jui 10, 2014	ne 1, 2, 3, 4, 5, 6, 9, and					
	Facility number: Provider number AIM number: 10	: 155196					
	Survey team: Dorothy Plumme Marsha Smith, R Karyn Homan, R Patsy Allen, SW 10, 2014)	N					
	Census bed type: SNF/NF: 67 Residential: 69 Total: 136						
	Census payor typ	e:					

State Form Event ID: QK5L11 Facility ID: 000103 If continuation sheet Page 17 of 26

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155196	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 06/10/2014
	PROVIDER OR SUPPLIER		3525 E	ADDRESS, CITY, STATE, ZIP CODE HANNA AVE IAPOLIS, IN 46237	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
R000273	Quality review c 2014; by Kimber 410 IAC 16.2-5-5. Food and Nutrition (f) All food prepara (excluding areas in maintained in accolocal sanitation an standards, including Based on observer record review the 69 of 69 resident in the kitchen, redistributed, and sconditions.  Finding include:  During the service 06-01-14 at 4:55 observed:	ential findings are cited th 410 IAC 16.2-5.  completed on June 17, rly Perigo, RN.  1(f)  all Services - Deficiency ation and serving areas in residents ' units) are ordance with state and d safe food handling	R000273	6/20/2014 R 273 Store/Prepare/ Serve-Sanitary Findings= Facility failed to ass 69 of 69 residents, who ate fo prepared in the kitchen, receiv food prepared, distributed and served under sanitary conditions. 1. What correct actions will be accomplished for those residents found to have been affected by the deficient practice; a. The residents have been assessed and no residents were identified as being negatively affected by the deficient practice(s). 2. How other residents having the	tive I

State Form Event ID: QK5L11 Facility ID: 000103 If continuation sheet Page 18 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPLI	ETED
		155196		LDING		06/10/2	2014
			B. WIN		ADDRESS OFTE STATE STREET		
NAME OF F	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP CODE		
					HANNA AVE		
ALIENH	EIM HEALTH & LIV	ING COMMUNITY		INDIAN	APOLIS, IN 46237		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	service line to ha	andle the bread with			potential to be affected by th	е	
	gloved hands when preparing chicken				same deficient practice will b	e	
	_	es. After staff had			identified and what corrective	е	
					actions will be taken; a. All		
		ing trays, the plates,			other residents have the poter	ıtial	
	ketchup bottle, le	ettuce, tomato, cheese,			to be affected by the deficient		
	handle of the sco	oop use to get the chicken			practice(s). b. The dietary sta		
	salad, and handled plate covers for the				and other facility staff will be in		
	· ·	•			serviced on the environmental		
	room trays. Same staff was observed a				sanitation and infection contro	ı	
	few minutes later handling the buns for				policy to cover areas such as;	,,	
	hamburgers/cheeseburgers with same				proper gloving, when to remove gloves, touching environmental		
	gloved hands.				surfaces and when to wash	1	
					hands, covering facial hair fully	,	
	Dietary Staff # 1	went out of the kitchen			with sanitary covers and other		
	-	e kitchen touching the			sanitary practices that are the		
		and did not change			policy of the Altenheim. c. Te	flon	
		and the not change			skillets showing signs of wear		
	gloves.				have been replaced with new		
					pans. 3. What measures will	II	
	Dietary Staff # 1	placed gloved hand into			be put into place or what		
	a large bag of po	otato chips and then			systemic changes will be ma	de	
		on the residents plates.			to ensure that the deficient		
	practa inc emps	on the residence places.			practice does not reoccur; a		
	Diatama eta 66 # 1	1: 11 6			The dietary staff and other fac	ility	
	1	did remove gloves after			staff will be in serviced on the		
		ys for C-Hall and placed			environmental sanitation and	_	
	on more gloves,	without washing hands.			infection control policy to cove areas such as; proper gloving,		
					when to remove gloves, touch		
	Dietary Staff # 1	was observe to wear a			environmental surfaces and w	-	
	1	leaving his mustache			to wash hands, covering facial		
		preparing and serving			hair fully with sanitary covers a		
		preparing and serving			other sanitary practices that ar	re e	
	the meal.				the policy of the Altenheim. b.		
					Teflon skillets showing signs of		
	On 6-10-14 at 9:	00 a.m., the			wear have been replaced with		
	Administrator pr	ovided the Policy 9.1			new pans. c. A CQR audit wi		
	•	Sanitation/Infection			conducted auditing the proper		
					sanitation techniques of staff,		
	i Common, dated 20	012, and indicated the	1		hand washing audits, equipme	ent l	

State Form Event ID: QK5L11 Facility ID: 000103 If continuation sheet Page 19 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITE	LDING	00	COMPLETED
		155196	B. WIN			06/10/2014
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIER	R			HANNA AVE	
ALTENHI	EIM HEALTH & LIV	ING COMMUNITY			APOLIS, IN 46237	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE ACTION OF THE APPROPRIATION OF THE APPROPRIATION OF THE APPROPRIATION OF THE ACTION	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	policy was the of	ne currently used by the			audits, proper gloving technique and other proper safe and	ies
	facility. The policy indicated, " A hair					
	restraint that effe	ectively cover head and			effective sanitation expectation to ensure compliance is met.	
	or facial hair (m	noustache and/or beard),			dietary manager or designee	THE
	`	od preparation areas.			will conduct random audits at a	all
	Hair is arranged to prevent contamination food equipment and utensils"				different meal times 7 days a	
					week to ensure	
	1000 equipment	and utensiis			compliance, weekly x 4 weeks monthly x 2 months and quarte	
	2) Dietary Staff # 2 was observed to get a skillet, butter, bread, cheese, and handle a spatula. Then prepare grilled cheese sandwiches without washing hands or				thereafter. 4. How the	
					corrective actions will be	
					monitored to ensure the	
					deficient practice will not rec	ur,
	changing gloves	•			i.e., what quality assurance	
	Changing gloves	•			program will be put into plac a. All audits will be brought to	
	0 (1014 ) 0	00 1			for a minimum of 120 days. b.	
	On 6-10-14 at 9:				The administrator/or designee	
	_	rovided the Policy 9.62			ensure compliance. 5. By	
	Environmental S	Sanitation /Infection			what date the systemic	
	Control dated 20	112, and indicated the			changes will be completed.	a.
	policy was the or	ne currently used by the			July 10,2014	
	facility.					
	_					
	On 6-10-14 at 9	30 a.m., review of Policy				
		ntal Sanitation /Infection				
		112. Under Procedure:				
		always washed prior to				
		•				
	1 2 2	s. When donning gloves,				
		is made with the				
		l come in actual contact				
		ch as the fingers. Gloves				
	come in a variety	y of sizes so that they fit				
	individual staff.					
	3. Disposable gle	oves are used to perform				
		as preparing sandwiches				
	thy are then disc					
		arada to provent				

State Form Event ID: QK5L11 Facility ID: 000103 If continuation sheet Page 20 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155196		(X2) MULTIPLE CC  A. BUILDING  B. WING	00	COMP	(X3) DATE SURVEY COMPLETED 06/10/2014			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  3525 E HANNA AVE INDIANAPOLIS, IN 46237					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
	contaminated in can occur when surfaces such as trash can, contact as from sneezing become torn"  3) ON 06-06-14 sanitation tour withree (3) of five damaged or miss On 06-01-14 at 4 # 2 prepared the sandwiches in a had scratches, per Teflon was gone.  During an intervious manager on 6-10 indicated the star policies are gone and staff received.	carded when they are any way. contamination touching unclean a refrigerator handle, at with bodily fluids (such gor coughing) or if they  at 1:10 a.m., During with the Dietary Manager (5) Teflon skillets had sing Teflon.  4:55 p.m., Dietary Staff grilled cheese skillet where the Teflon celing Teflon, or the						
R000349								

State Form Event ID: QK5L11 Facility ID: 000103 If continuation sheet Page 21 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155196		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	COMPLETED  06/10/2014			
	OF PROVIDER OR SUPPLIES		STREET ADDRESS, CITY, STATE, ZIP CODE  3525 E HANNA AVE INDIANAPOLIS, IN 46237				
(X4) II PREFI TAG	X (EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE		
	employee of the fresponsibility. The follows: (1) Complete. (2) Accurately doe (3) Readily access (4) Systematically Based on record the facility faile records contained specimens order of 8 residents recomplete and accurate (Residents #438).  Findings included 1. The clinical rewas reviewed on Diagnoses for the were not limited blood pressure.  A physician's or indicated the faccurate obtain a stool specimens ranging threatening inflaction and evelop after medication. The	sible.  organized. review and interview, d to ensure clinical ed results for laboratory red by the physician for 3 viewed for having curate clinical records. , #452, and #405)  e:  ecord of Resident #438 in 6/9/14 at 9:15 a.m. the resident included, but d to, depression and high  der, dated 3/21/14, cility was supposed to recimen from the resident stridium difficile. (C-diff rium which can cause ing from diarrhea to life immation of the colon. It is the use of antibiotic is resident had been taking a wound on her ankle	R000349	Date: 6/20/2014 Tag # R3 Clinical Records/noncomplian Description of findings: The facility failed to ensure clinical records contained results for laboratory specimen's ordered the physician for 3 of 8 resider reviewed for having complete accurate clinical records. (Residents # 438, # 452 and 405) What Corrective action will be accomplished for those residents found to have been affected by the deficient practical to Physician and family notified and to Laboratory. A Residents # 438, 452 and 400 were assessed and no abnorating from the deficient practical businesses and the properties are appropriate. Labse returned with results within normal limits. How other residents having the potential be affected by the same definity practice will be identified and what corrective action(s) will taken? 1. All resident s who have ordered labs have the potential to be affected by this deficient practice and will be	al ed by ents e and  # n(s) se n ctice? 438, ely y 2. 55 rmal ctice, eutic		

State Form Event ID: QK5L11 Facility ID: 000103 If continuation sheet Page 22 of 26

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	ETED
		155196	B. WIN			06/10/	2014
			_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	t .			HANNA AVE		
ALTENH	EIM HEALTH & LIV	ING COMMUNITY			APOLIS, IN 46237		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ГЕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	indicated, "Acut yesterday. 'Greek Keflex (an antib monthcertainly A nurse's note, do p.m., indicated the collected and reapick up. The nospecimen was ruled. The nospecimen was ruled. The nospecimen was ruled to the collected and reapick up. The nospecimen was ruled. The nospecimen was ruled to the collected and reapick up. The nospecimen was ruled to the collected and reapick up. The nospecimen was ruled to the collected and reapick up. The nospecimen was not done thought it might because the residual to the collected and reapick up. The clinical ruled to discontion to the collected and reapick up. The clinical ruled to discontion the collected and reapick up. The clinical ruled to discontion the collected and reapick up. The clinical ruled to the collected and reapick up. The nospecimen was ruled to the collecte	lated 3/21/14 at 8:13 he stool specimen was ady for the laboratory to te indicated the stool anny and pale.  this laboratory test were dent's record. During an ne Unit Manager on o.m., she indicated the e. She indicated she have been discontinued, dent stopped having loose cated she did not have an			audited for completion. 2. All Physicians orders will be read and checked in Morning clinical meeting by the Unit managers designee. 3. Lab orders will be verified monthly to ensure no duplicate orders exist. 4. The director of nursing or designee will be responsible to ensure compliance. What measures were be put into place or what syste changes will be made to ensure that the deficient practice does not recur? 1. All Physicians orders will be read and checked in Morning clinical meeting by Unit managers/or designee. 2 Laboratory orders will also be verified monthly to ensure no duplicate orders exist. 3. Lab results/orders will be tracked be unit manager or designee to ensure completion. 4. The director of nursing or designee will be responsible to ensure compliance. How the correct action(s) will be monitored to ensure the deficient practice we not recur, i.e., what quality assurance program will be put into place? 1. All audits will be brought to QA for a minimum of 120 days. 2. The administrate or designee will ensure compliance. By What date the systemic changes will be completed? 7/10/2014	all /or pe will emic re s ed the .	
		ent #452 was supposed to					

State Form Event ID: QK5L11 Facility ID: 000103 If continuation sheet Page 23 of 26

AND PLAN OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155196		(X2) MULTIPLE ( A. BUILDING B. WING	00	COM	(X3) DATE SURVEY COMPLETED 06/10/2014	
	PROVIDER OR SUPPLIER		3525	TADDRESS, CITY, STATE, ZIP CO E HANNA AVE NAPOLIS, IN 46237	)DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION  PREFIX (EACH CORRECTIVE A CTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
	have a BMP and A BMP is a basi blood laboratory blood sugar, kiddelectrolytes like A CBC is a commeasures white a BMP's were not record for the mandarch, and Aprifound in the clin months of Febru June 2014.	a CBC drawn monthly. c metabolic panel, a tests which measures ney function, and sodium and potassium. plete blood count which and red blood cells.  found in the clinical onths of February, 1 2014. CBC's were not ical record for the ary, March, April, and				
	Manager, on 6/9 indicated she wa	iew with the Unit /14 at 12:00 p.m., she is unable to find any BC lab results since the in on 8/15/13.				
	reviewed on 6/09 Diagnoses include to, congestive he the heart to pume the body), diabet	ded, but were not limited eart failure (inability of p enough blood through tes (high levels of sugar d hypertension (high				
	11/19/13, indica metabolic panel	ysician orders signed ted an order for a basic (BMP) (blood test that n about the body's				

State Form Event ID: QK5L11 Facility ID: 000103 If continuation sheet Page 24 of 26

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: 155196	A. BUILDI	NG	00		PLETED 0/2014			
		100100	B. WING	TTD FFT :	DDDEGG CITY OT TO COPE	00/10/	40 I <del>T</del>			
NAME OF F	PROVIDER OR SUPPLIER			DDRESS, CITY, STATE, ZIP CODE						
ALTENHEIM HEALTH & LIVING COMMUNITY				3525 E HANNA AVE INDIANAPOLIS, IN 46237						
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION DATE				
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			EFIX FAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)					
1110	metabolism) lab test every month.						5.112			
	No BMP lab test									
	the clinical record for December 2013,									
	February 2014, March 2014, nor April 2014.									
	During an inters									
	During an interview 6/09/14 at 2:30 p.m., the Residential Unit Manager indicated									
	she was unable to locate BMP lab results									
	for December 2013, February 2014, March 2014, nor April 2014.									
	1, 101	71pm 201 i.								
	During an interview with the Unit									
	Manager on 6/9/14 at 12:00 p.m., she									
	indicated when lab comes to collect									
	specimens, they write the resident's name									
	and test in a facility lab book. She									
	indicated the fac	ility did not have a								
		for checking to see if								
	labs were drawn	, results received, or								
	physician's notif									
		30 a.m., the Director of								
		d the Reports of Lab,								
		r Diagnostic Examination								
	_	ny 2012, and indicated								
		ne one currently used by								
		cility. The policy								
	indicated, "Lab,	-								
	diagnostic exam									
	l ~	lered by the physician.								
		nall be notified of the								
results, and this information shall be										
	recorded in the r	esident's medical								

State Form Event ID: QK5L11 Facility ID: 000103 If continuation sheet Page 25 of 26

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/02/2014 FORM APPROVED OMB NO. 0938-0391

-	IENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IN OF CORRECTION IDENTIFICATION NUMBER:  155196		(X2) MULTIPLE CO A. BUILDING		ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/10/2014			
NAME OF PROVIDER OR SUPPLIER  ALTENHEIM HEALTH & LIVING COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE  3525 E HANNA AVE INDIANAPOLIS, IN 46237					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	record."								

State Form Event ID: QK5L11 Facility ID: 000103 If continuation sheet Page 26 of 26